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Teachers' Perception of Mental Health in the School System

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(TITLE)

BY

Nicholas Caldwell

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**THESIS**

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS  
FOR THE DEGREE OF

**MASTERS OF SCIENCE IN SCHOOL COUNSELING**

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IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY  
CHARLESTON, ILLINOIS

2019

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## **DEDICATION**

I would like to dedicate my thesis to my family for your support and encouragement throughout the years. You are the reason I am here today, and you are the reason I have succeed in the face of any obstacles. I am truly blessed for the opportunities in my life, and your hard work, guidance, and dedication to supporting me have provided me with the strengths and values I have to this day.

To my mother, thank you for the love and support you provide me. Your trust in me and my abilities have allowed me to grow into the successful man you believed I could become. I am forever grateful for you and will be with you and my father every step of the way for the future. You have had a huge impact on me, and I know you will continue to positively impact me.

To my father, thank you for the wisdom you have provided me over the years. I appreciate your strength and guidance and will always love you for it. You have been my foundation for growing and developing into someone you could be proud. I will continue to navigate my future from the wisdom and experiences I have had from you leading the way.

To my wife, thank you for the love and support you provide me. You have been my best friend throughout the last several years. I could not have made it to where I am at without your love and support. I look forward to the many years I will spend with you in the years down the road. I am happy to begin a new chapter in my life with you upon the completion of this thesis.

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I would like to thank my committee members, Dr. Dianne Timm and Dr. Jon Coleman. Your dedication and commitment to helping me complete this thesis project are sincerely appreciated. Thank you for your unique perspectives and insight throughout the thesis process. Your thoughtfulness was also noticed and appreciated. I strongly believe that I am a more thoughtful researcher from listening to your comments and critiques. I truly appreciate having the opportunity to work with both of you.

Finally, I would like to thank the administration of the participating school. I appreciate the opportunity to conduct research at this excellent institution of education. Without the approval of the administration, this thesis would not be possible. Thank you for your willingness to provide your teachers with the opportunity to have a voice in the school system.

**ABSTRACT**

The study examined teachers' perceptions of their school's mental health system. Specifically, teachers were asked about their role in the identification process, how effective their school's system is at identifying and treating mental health problems, and their suggestions for improvement. Mental health problems affect a significant portion of today's youth (Merikangas et al., 2010). Mental health problems can negatively impact an adolescent's academic achievement, social relationships, and behavioral functioning (Woodward & Fergusson, 2001). Six teachers from a southeastern, rural Illinois high school participated in the study. Each teacher participated in a single interview and discussed their perceptions of the school's mental health system. Results indicated that teachers generally believed they were the first identifiers of mental health problems, will refer students to the counselor, feel somewhat prepared, believe their relationship strongly impacts students, would like more training in mental health, want to be invested in training but may hesitate due to a lack of time, would like professional development units for attending trainings, and want trainings to be meaningful.

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## CHAPTER I

### **Introduction**

It is normal for adolescents to experience some degree of mental health problems (Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, 1998). Adolescents may experience stressors and difficulties through social or hierarchical relationships including peer bullying; peer pressure; problems with teachers; and conflicts with peers, parents, or siblings (Steinberg & Morris, 2001; Zimmer-Gembeck & Skinner, 2008). Many adolescents also experience difficulties with academics (Steinberg & Morris, 2001; Zimmer-Gembeck & Skinner, 2008), emergence of self-identities, the development of self-concepts, and the use/misuse of illicit substances (Steinberg & Morris, 2001). Roughly one in five adolescents live in households that are poor (National Center for Children in Poverty, 2017), which may adversely impact childhood and adolescent emotional, behavioral, and mental development (Yoshikawa, Aber, & Beardslee, 2012) and academic achievement (Anderson, Leventhal, & Dupéré, 2014). These conditions may exacerbate feelings of isolation, stress, and fear of failure in adolescents (Clark, 2011). These contributing factors inhibit healthy child and adolescent development and may increase the risk of developing mental health problems (Mychailyszyn et al., 2011).

Adolescents who are referred for mental health services are often referred by teachers because of the significant amount of time spent with them in the classroom (Mychailyszyn et al., 2011). Many adolescents develop strong and positive relationships with trusted teachers that they are unlikely to have with other adult figures (Fredriksen & Rhodes, 2004). Adolescents who are at-risk for developing a mental health problem need to be identified and referred by a teacher for them to receive the necessary services for normal classroom functioning (Johnson, Eva,

Johnson, & Walker, 2011) and long-term mental health (Mychailyszyn et al., 2011). Likewise, it is important for teachers to recognize their significant role in identifying adolescents with mental health problems (Johnson et al., 2011) and identifying these students accurately and efficiently (Dwyer, Nicholson, & Battistutta, 2006).

School counselors have an important and integral role in the process of addressing mental health problems within the school system (Erford, 2015). School counselors are responsible for the personal and social development of students by designing, implementing, and enhancing comprehensive programs for student success (American Counseling Association [ACA], American School Counseling Association [ASCA], & National Education Association [NEA], 2008). They may assist students in their personal and social development through delivering school guidance curriculum, individual student planning, and responsive services (e.g., individual counseling, group counseling, psychoeducation; ACA et al., 2008). However, for students to receive individualized or small group-based services, students must be identified and referred (Johnson et al., 2011).

If teachers cannot effectively identify and refer students with mental health problems, school counselors may need to revise their roles in the mental health identification process. For example, school counselors may need to more frequently conduct functional behavioral assessments to better understand individual students and their needs in the classroom environment (Scott, Bucalos, Liaupsin, Nelson, Jolivet, & DeShea, 2004). However, a school counselor cannot be responsible for developing the necessary relationship with every student for which they are responsible to alleviate their mental health problems (Paisley & McMahon, 2001). Counselors are often responsible for providing services for 300 to 1,200 students (ACA, 1999), despite the recommendation of the American School Counselor

Association a student-to-counselor ratio of 250:1 (ACA et al., 2008). Thus, it is important to identify teachers' perceptions of their role in the process of identifying and subsequently treating mental health problems for school counselors to appropriately provide services.

### **Statement of Purpose**

The study examined the perceptions of teachers in the process of identifying and treating mental health problems within their school system. Teachers are already an integrated part of the identification of students with mental health problems. Teachers' perceptions are important to understand in determining the subsequent roles of the teachers and school counselors in the identification process of students with mental health problems. Understanding these roles may assist students in receiving services and counselors in providing those services for students.

### **Research Questions**

The focus of the study is on three major research questions. These research questions are the following:

Research Question #1: How do teachers perceive their role in identifying  
mental health problems within the school system?

Research Question #2: How do teachers perceive the effectiveness of the  
identification and treatment of mental health problems  
within their school?

Research Question #3: What improvements do teachers have to address mental  
health problems within the school?

### **Limitations**

This qualitative study was limited to one geographical area (i.e., southeastern, rural Illinois). It was also limited to volunteers who were not incentivized to

participate in the study. Because of these limitations, the results may not be generalizable to teachers across the country. The study relies on accurate and honest responses from teachers on how they perceive their own school's mental health system and their suggestions for improvement. Six teachers participated in the study and provided only six perspectives that may not represent all of teachers in the school district. To mitigate these limitations, the researcher developed rapport with each participant and confidentiality was maintained during and after the interview. The researcher also maintained the highest degree of confidentiality possible regarding the responses of each teacher. The responses of individual participants are not identifiable based on the presentation of the results in this thesis.

The researcher had some degree of interviewer bias from the formation of the research questions and subtle nonverbal responses during the interview. The research questions may have assumptions and biases about teachers and their role in identifying mental health problems (e.g., teachers already have a role in identifying mental health problems). The presence or lack of presence of certain questions asked by the researcher may affect the results of the study. To minimize the effects of the presence of questions, the researcher utilized a protocol with broad, open-ended questions and allowed the teacher to elaborate on each research question. The researcher also did not deviate from the script of questions during the interview.

The researcher's credentials and lack of relationship with the participants may affect disclosure, affecting the results of the study. The researcher developed rapport with each participant and disclosed educational credentials held by each research team member and the affiliated researching institute. Discussing the limitations of the study is important in considering the value, credibility, and generalizability of the study's results.

**Operational and Conceptual Definitions**

**Adolescence.** Adolescence refers to “the period between the onset of puberty and the cessation of physical growth; roughly from 11 to 19 years of age” (The Free Dictionary, 2018).

**Credentials.** Credentials refer to formal qualifications from institutions, such as a high school diploma, Bachelor of Arts, or master’s degree.

**Mental health.** Mental health has been broadly defined by the World Health Organization (WHO) as “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (WHO, 2016).

**Mental health disorder.** A mental health disorder is “a clinically recognizable set of symptoms or behaviors associated in most cases with distress and with interference with personal functions” (WHO, 1992, p. 5). For this study, a mental health disorder refers to an adolescent who meets the criteria for a clinically significant mental health problem (e.g., major depressive disorder, social phobia).

**Mental health problem/difficulty.** Mental health problems or difficulties are changes in thinking, mood, and/or behavior that impair functioning (Humphrey & Wigelsworth, 2016). For this study, a mental health problem is more inclusive than a mental health disorder. For example, a constantly disruptive child might be problematic for a teacher, but the child may not meet the criteria for having a mental health disorder (c.f., Humphrey & Wigelsworth, 2016).

**School-based mental health services.** School-based mental health services are “the broad array of services designed to prevent and treat behavioral and emotional difficulties that may or may not be symptoms of specific mental disorders” (Christner, Mennuti, & Whitaker, 2009, p. 5).

**School counselor.** School counselors refer to a specific position within the school that is responsible for improving the academic achievement, personal and social development, career planning for students (ACA et al., 2008).

**Teacher.** For this study, a teacher is a faculty member within a high school who normally and regularly contacts students for at least 20 hours per week in a classroom setting.

**Teacher nomination.** A teacher nomination is the identification of a student within his or her classroom who exhibits symptoms of a specific form of psychopathology (e.g., Cunningham & Suldo, 2014).

### **Conclusion**

Many adolescents experience mental health problems. In the school system, teachers typically refer students for services provided by school psychologists, school counselors, and social workers. Teachers may need training to improve mental health identification or may have unique ideas for how to improve their school's mental health system. School counselors may need to revise their roles to help in the mental health identification process since they have formal training in student mental health. This study explored how teachers perceived their role in the mental health identification process, the effectiveness of their school's mental health system, and any suggested improvements their school's mental health system.

## CHAPTER II

### **Literature Review**

In this chapter, the relevant literature regarding mental health problems in adolescents, mental health treatment in the school system, teachers' perceived roles in the mental health process, teachers' perceptions on mental health training, and their accuracy of mental health identification are reviewed. Understanding the current literature regarding these topics is important in providing context and a wholistic understanding of teachers' previous perceptions within the school framework, may inform the researchers on appropriate interview questions, and directions for future research. The literature will focus on mental health in adolescents since they are the target population of the study.

#### **Mental Health Problems in Adolescents**

Mental health problems affect many aspects of life (Harpin, 2005). Mental health problems can affect an adolescent's relationship to others (e.g., parents, peers, authority figures) and in different environments (e.g., home, school, public; Mychailyszyn et al., 2011; Rapee, 2015). Mental health disorders commonly inhibit age-appropriate behaviors and social interactions necessary for lifelong healthy development (Mychailyszyn et al., 2011).

Mental health problems affect many adolescents. Clinically significant mental health problems affect one in ten children and adolescents (Green, McGinnity, Meltzer, Ford, & Goodman, 2005), and mental health problems affect youth across the life span (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005; Merikangas et al., 2010). Lifetime prevalence estimates indicated that almost half of adolescents meet the criteria for at least one non-clinically significant mental health problem, and over one-fifth of adolescents meet the criteria for at least one clinically

significant mental health problem (Merikangas et al., 2010). Adolescents are most at-risk for developing anxiety disorders (31.9%) and behavior disorders (19.6%; Merikangas et al., 2010). However, the severity of the disorder depends on its diagnosis (Merikangas et al., 2010). For example, 14.3% of adolescents met the criteria for any mood disorder, but 78% of those adolescents met the criteria for a clinically significant mood disorder (Merikangas et al., 2010). On the other hand, 31.9% of adolescents met the criteria for any anxiety disorder, but only 26% of those adolescents met the criteria for a clinically significant anxiety disorder (Merikangas et al., 2010). Co-morbid mental health problems also affect adolescents as 19.3% of adolescents met the criteria for two or more mental health problems and 6.0% of these adolescents meeting the criteria for a clinically significant mental health problem (Merikangas et al., 2010).

**Mental health development.** It is important for mental health treatment professionals, such as school counselors, to be familiar with the developmental nature of their students' mental health problems (Greenberg et al., 2003). Through consultation with parents, teachers, and other individuals familiar with the student, treatment professionals can better understand the developmental nature of the mental health problem to address the identifiable causes of the problem (Dowdy et al., 2015). School counselors may use this information to determine appropriate data-based interventions (Dowdy et al., 2015).

Mental health problems affect individuals differently across the lifespan (Merikangas et al., 2010). Signs of mental health problems can occur as early as seven to eight months of age (Huberty, 2012). However, by two years-old, it is developmentally appropriate for the child to develop adaptive skills where he or she may be approached by strangers (e.g., child care workers) or separated from



caregivers without significant behavioral or emotional problems (Huberty, 2012).

Symptoms of separation anxiety are expected to occur in children when they are first separated from the primary caregivers, but these symptoms are not expected to cause significant problems (Huberty, 2012).

The environment may be a contributing factor to the development of mental health problems. Overprotective parenting was associated with social anxiety in children (Greco & Morris, 2002), and social anxiety in youth has a significant and positive relationship with social anxiety among college students (Spokas & Heimberg, 2009). Both overprotective parenting and coercive parenting can influence the development of social anxiety during childhood (Laurin, Joussemet, Tremblay, & Boivin, 2015).

Biological factors also have a role in the development of mental health problems. Genetic influences prominently affect disorders, although evidence suggests that each disorder may not have the same degree of genetic influence (Kendler, Prescott, Myers, & Neale, 2003). For example, alcohol dependence and drug abuse/dependence had the strongest genetic influence of seven studied syndromes, but individuals with conduct disorder and adult antisocial disorder share common environmental factors (Kendler et al., 2003).

Adolescents experience mental health problems differently based on their age and gender. Merikangas et al. (2010) conducted a face-to-face survey of 10,123 adolescents between the ages of 13 and 18 years within the United States. Their study focused on estimating the lifetime prevalence of DSM-IV mental disorders based on sociodemographic information. Mental disorders were categorized as being or not being severely impaired and comorbidity across disorders was documented. Results indicated that girls met the criteria for mood disorders and eating disorders twice as

often as men and were more likely to have met the criteria for an anxiety disorder (Merikangas et al., 2010). However, boys were more likely to have met the criteria for behavioral disorders than women (Merikangas et al., 2010). Lastly, age also plays an important role in the development of mental health problems. The presence of mood disorders and alcohol abuse/dependence significantly increased from 13- and 14-year-olds to 17- and 18-year-olds (Merikangas et al., 2010). However, age did not significantly change the presence of anxiety or behavior disorders (Merikangas et al., 2010).

### **Importance of Identification**

Early and accurate identification of mental health problems is crucial for the positive and healthy development of the child (Lane & Menzies, 2003; Weist, Rubin, Moore, Adelsheim, & Wrobel, 2007). When a child is identified as at-risk, they are further assessed to determine the nature of the problem and receive subsequent services (Eklund et al., 2009). Strong evidence links school-based mental health services to positive outcomes (Center for School Mental Health, 2012). For example, interventions targeting mental health problems can lead to academic improvement since mental health problems are often barriers to the learning process (CSMH, 2012). Students are more engaged, feel a greater sense of connectedness to the school, and have lower rates of emotional and behavioral symptoms after receiving mental health services in the school (CSMH, 2012).

Research has focused on available methods of recognizing students with mental health problems that are convenient and inexpensive for schools to use (e.g., Dowdy et al., 2015; Eklund et al., 2009). Universal screenings, which are systematic forms used to identify or predict students who are at-risk for mental health problems, are one of the most reliable methods of assessment (Miller, Cohen, Chafouleas, Riley-

Tillman, Welsh, & Fabiano, 2015). However, the expenses for universal screenings add up and take valuable time and resources from students and teachers (Miller et al., 2015). Office disciplinary referrals, which schools often use to document incidents such as aggression and disruption, are not a reliable assessment (Miller et al., 2015). Teacher nomination is an inexpensive method that has demonstrated fair reliability (e.g., Dwyer, et al., 2006).

**Under identification.** Many students go through school undetected and untreated for their mental health problems (Chavira, Stein, Bailey, & Stein, 2004). Adolescents are often reluctant to seek out the mental health services they need and often require parents or teachers to refer them for mental health services (Gulliver, Griffiths, & Christensen, 2010). Child and adolescent reluctance may be due to the stigma associated with having mental health problems (Gulliver et al., 2010). This stigma derived from adolescents' fear about what others, including the mental health professional, might think of them if they were to seek help (Gulliver et al., 2010). Reluctance for seeking assistance for mental health problems also includes concerns over other people finding out about their seeking assistance and ensuing embarrassment, lack of self-awareness of the mental health problem, lack of accessibility to services, and the belief that the individual can treat his or her own mental health problems (Gulliver et al., 2010).

Some mental health problems seldom create problems for regular classroom activities and may lead to less teacher recognition of the mental health problem (Lane & Menzies, 2003). These students may go unnoticed and will not receive services in the schools (CSMH, 2012). Adolescents ( $N = 10,123$ ) with attention-deficit hyperactivity-disorder (ADHD; 59.8%) and behavior disorders (45.4%) are most likely to have received services for their mental health problems (Merikangas et al.,

2011). Adolescents with substance use disorders (15.4%) and anxiety disorders (17.8%) were the least likely to have received services for their mental health problems (Merikangas et al., 2011). Certain adolescent demographics may be less likely to be recognized and referred as problematic. Adolescent women with an eating disorder were eight times more likely to receive treatment than adolescent men with an eating disorder (Merikangas et al., 2011). Likewise, adolescent women with panic disorder and separation anxiety were three and two times, respectively, more likely to receive treatment than their male counterparts (Merikangas et al., 2011). The severity of the disorder affects whether an adolescent receives services. Half of adolescents with severe cases of any type of disorder received treatment, but only one-quarter of adolescents with non-severe cases of any type of disorder received treatment (Merikangas et al., 2011).

**Outcomes for individuals.** Many short-term and long-term negative outcomes are associated with mental health problems (Green et al., 2005; Woodward & Fergusson, 2001). Students with mental health problems are less adaptive to school functioning. They have poorer school performance based on parent ratings (Wood, 2006), had worse attendance (Egger, Costello, & Angold, 2003; Green et al., 2005), less school enjoyment (Van Ameringen, Mancini, & Farvolden, 2003), higher rates of truancy (Green et al., 2005), higher rates of dropping out of high school (Kessler, Foster, Saunders, & Stang, 1995; Van Ameringen et al., 2003), lower likelihood of attending postsecondary education (Kessler et al., 1995; Woodward & Fergusson, 2001), and higher rates of dropping out of postsecondary education (Kessler et al., 1995) than students without mental health problems. In the classroom, students with mental health problems have lower engagement, concentration, and interaction with others (Huberty, 2008).

Students with mental health problems have more negative social outcomes compared to students without anxiety-related problems (Mychailyszyn et al., 2011). Nijs et al. (2014) conducted a study with 11,130 adolescents between the ages of 11 and 19 years of age in the Netherlands. The researchers found that adolescents who self-reported clinically significant mental health problems felt less safe in school (Nijs et al., 2014). Participants also reported victimization from bullying and peer problems (Nijs et al., 2014), which may have contributed to their feelings of a lack of safety at school.

Green et al. (2005) conducted a survey to identify the prevalence of mental health disorders and identify behavioral patterns of adolescents with these disorders. They interviewed 7,977 children between the ages of 5 and 16 years of age and found students with mental health problems were less likely to make and keep friendships (Green et al., 2005). The researchers also found that adolescents with mental health problems had less family and friends to whom they felt close (Green et al., 2005).

There are several long-term consequences for youth who have mental health problems. Children and adolescents who have untreated mental health problems have a greater chance of developing comorbid mental disorders in adulthood (Copeland, Shanahan, Costello, & Angold, 2009; Pine, Cohen, Gurley, Brook, & Ma, 2003). An estimated half of adults with mental health problems trace the development of their mental health problem to their childhood or adolescence (Belfer, 2008). When left untreated, children with high yet not clinically significant anxiety were less satisfied with family and work relationships later in life (Kim-Cohen, Caspi, Moffitt, Harrington, Milne, & Poulton, 2003). Even with treatment, the long-term effects of mental health problems can last at least one decade (Yule, Bolton, Udwin, Boyle, O'Ryan, & Nurrish, 2000). Research indicates that adolescents with at least one

emotional disorder are more likely to self-harm, attempt suicide, smoke, drink, and use drugs (Green et al., 2005).

Woodward and Fergusson (2001) conducted a 21-year longitudinal study of a cohort of 1,265 adolescents (14-16 years-old) in New Zealand. They studied the psychological, education, and social outcomes for individuals without anxiety disorders, with one anxiety disorder, two disorders, or three anxiety disorders. The presence of anxiety disorders in adolescents increased the presence of depression and conduct disorder in adulthood, and substance abuse (i.e., illicit drugs and alcohol dependence) was more frequent among adolescents with anxiety disorders (Woodward & Fergusson, 2001). Per Woodward and Fergusson (2001), the presence of one anxiety disorder nearly doubled the rate of alcohol dependency (14.8%), and the presence of three disorders more than doubled that rate (30.8%).

Research suggests that individuals often engage in high risk behavior when they have a mental health problem. Individuals drank alcohol more frequently and in higher quantities to try to manage their panic disorders (Kushner, Abrams, Thuras, & Hanson, 2000) and social anxiety (Thomas, Randall, & Carrigan, 2003). Stewart and Conrod (2002) found that diagnoses of anxiety-related disorders often predate alcohol use disorders. Woodward and Fergusson (2001) also found that the presence of an anxiety disorder increased suicidal behavior. Adolescents with anxiety disorders from families with a low-socioeconomic status had a greater likelihood of early motherhood; a weaker parent-child attachment; and higher rates of the following: maternal educational underachievement, regular and severe physical punishment, sexual abuse, and parental alcohol problems (Woodward & Fergusson, 2001).

**Benefits of early intervention.** According to Dowdy, Ritchey, and Kamphaus (2010), there is a growing effort to change the present system of mental

health treatment. Present models focus on reduction of symptomology and increasing of normal behaviors after symptoms are present and impair daily functioning (Dowdy et al., 2010). The newer model of treating mental health problems shifts from a reactive and individual model towards a universal model of prevention (Dowdy et al., 2010). The shift in focus is in part due to the problems associated with the previous model: the prevalence of untreated mental health problems, difficulties in reducing problematic symptoms, increasingly limited resources available for schools, and increasing demand for mental health services (Dowdy et al., 2010). As schools and school personnel are faced with these problems, new and innovative methods are needed to promote successful student outcomes (Dowdy et al., 2010).

Early intervention for mental health problems may lead to more meaningful and beneficial outcomes (Dowdy et al., 2010). Early mental health services may help prevent severe symptomology and reduce symptoms already present (Dowdy et al., 2010). For children and adolescents, the likelihood of academic failure and future life difficulties decreased through prevention and intervention strategies (Eklund et al., 2009; Lane & Menzies, 2003). Early interventions also helped children develop necessary coping skills to manage the problems they faced as they develop and advance through their education (Hirshfeld-Becker & Bierderman, 2002). However, the staff's ability to identify at-risk students influences the delivery of services (Lynch, Wood, Livingood, Smotherman, Goldhagen, & Wood, 2015). The quality of the mental health services is important for reducing symptoms and increasing the functioning of students with mental health problems (Lynch et al., 2015).

### **Mental Health in Schools**

Mental health problems are often addressed in schools because they impair a student's ability to function within the school system (Mychailyszyn et al., 2011).

Schools have numerous advantages which make them ideal settings for identifying, intervening, and treating students to necessary mental health services (Humphrey & Wigelsworth, 2016; Stephan, Sugai, Lever, & Connors, 2015). Students spend a large amount of time in the school setting (Rutter, Maughan, Mortimore, Ouston, & Smith, 1979). Services can be implemented throughout most of the individual's early life (Humphrey & Wigelsworth, 2016). Because of the variety of settings within the school (e.g., gym, lunchroom, music class), and there is more opportunity for generalization and maintenance of treatment gains (CSMH, 2012). Students' progress toward regular functioning can be monitored in a school setting (Dowdy et al., 2015). Interventions by community agencies are time-consuming, expensive, and do not easily transfer into interventions or accommodations within the school setting (August, Piehler, & Miller, 2018). This may be why research has found that students often receive mental health services in the schools (Foster, Rollefson, Doksum, Noonan, Robinson, & Teich, 2005; CSMH, 2012).

Research has suggested the use of a multi-tiered system that integrates the academic, social, emotional, and behavioral needs of students and may benefit all students if well-implemented (Macklem, 2011; Stephan, et al., 2015). This system is referred to as a Response-to-Intervention (RtI) model. RtI is composed of three tiers and is implemented to provide a continuum of support for students based on their identifiable social, emotional, and behavioral needs (Lane, 2007; Stephan et al., 2015). RtI is designed for school-based mental health personnel, such as the school counselor, to work collaboratively with teachers to provide student-based services in an efficient way (Stephan et al., 2015).

The first tier within the RtI model addresses the academic, social, emotional, and behavioral needs of all students within the school (Stephan et al., 2015). These



students receive high-quality and evidence-based support of their needs implemented at a school- or class-wide level (Stephan et al., 2015). Students who struggle beyond this base support-system are identified and receive more intensive services (Stephan et al., 2015). If correctly implemented, approximately 80% of students fall into the first tier and do not require more intensive services (Lane, 2007; Stephan et al., 2015). Tier I services may include schoolwide behavioral expectations enforced in all classrooms and in the hallways and may be enforced by all faculty (Stephan et al., 2015). Students in tier II often receive social, academic, behavioral, or emotional support in small group settings or less intensive one-on-one services (Stephan et al., 2015). Approximately 10 to 15 percent of students fall into the second tier (Lane, 2007; Stephan et al., 2015). Examples of tier II services include social skills training or conflict resolution for groups, and Check-In-Check-Out (CICO) for individual students. Tier III involves intensive support for students whose needs are not met in the first two tiers. Interventions are individualized and progress is frequently monitored to help reduce current problematic behaviors and significantly increase daily social, emotional, behavioral, and academic functioning (Stephan et al., 2015). Approximately five to seven percent of students fall into the third tier in this model (Horner & Sugai, 2000). An example of tier III services includes the use of function-based interventions (Stephan et al., 2015).

School counselors have well-integrated roles within the RtI system (Erford, 2015). In the first tier, school counselors use standards- and competency-based curriculum presented schoolwide to students (Hatch, 2014). In the second tier, school counselors implement preplanned and research-based interventions to address the individual's or group's academic, behavioral, or social-emotional concern (Hatch,

2014). In the third tier, school counselors provide intensive services to individuals (Hatch, 2014).

### **Teacher Identification of Mental Health Problems**

School counselors and other faculty (i.e., social workers, school psychologists, and school nurses) are co-responsible for the treatment of students' mental health problems within the school setting (Foster et al., 2005). Many students have mental health problems, but these faculty rarely are in the position to be the first to identify a student with a mental health problem. They lack the time and resources to observe and develop relationships with students to the same degree that teachers do (Erford, 2014). Thus, treatment faculty frequently rely on referrals by classroom teachers (Eklund et al., 2009).

**Importance of the teacher.** Teachers are in a unique and crucial position because maladaptive behaviors are easier to identify in a classroom setting (Johnson et al., 2011; Mychailyszyn et al., 2011). The behaviors of many children can be compared on a relatively normative scale, and teachers frequently observe typical behavior compared to deviant behavior (Headley & Campbell, 2011). That is, teachers make referrals of students for mental health services based on their relationships with students and the teacher's knowledge of the deviant behaviors, social skills, and affective states that students with mental health problems exhibit (c.f., Auger, 2004; Cunningham & Suldo, 2014; Moor et al., 2007). Thus, teachers are a necessary link for children to receive timely services in the school setting (Mychailyszyn et al., 2011).

Teachers are an asset to students (Fredriksen & Rhodes, 2004). Students often look at teachers as role models and sources of knowledge and advice (Fredriksen & Rhodes, 2004). Because of this relationship, students often confide for help with

personal problems in teachers and may develop strong teacher-student relationships if teachers are supportive of the student (Fredriksen & Rhodes, 2004). Evidence suggests that higher quality teacher-student relationships are associated with desirable outcomes, such as higher academic achievement and greater cognitive skill development (O'Connor & McCartney, 2007). Teachers can effectively support and refer at-risk students to proper mental health services from this unique relationship (Kourkoutas & Giovazolias, 2015).

Parents and other adult figures outside the school setting may not have the same advantages as teachers. Parents often fail to recognize that their child has a mental health problem (Teagle, 2002). Parents cannot readily compare their child's behavior to the normative behavior of fifteen to thirty same-aged peers to informally determine behavioral deviance (Headley & Campbell, 2011). If parents perceive a problem, there may be additional barriers to the child's reception of services, including the stigma of mental health services, the cost of treatment, parental desire for control over the child's treatment process, and the desire to handle difficult situations within the family (Thurston & Phares, 2008). These reasons may explain why roughly three-quarters of students who received mental health services received them in the school setting (Allen, 2011).

**Teacher-perceived role.** Most teachers generally recognize their role in the identification process (Andrews, McCabe, & Wideman-Johnson, 2014; Reinke, Stormont, Herman, Puri, & Goel, 2011) although they may struggle to clearly define their role (Alisic, 2012). Andrews et al. (2014) conducted an online survey to examine teachers' knowledge regarding mental health issues and their perceived roles in the mental health process. The survey consisted of 42 questions using a Likert scale where teachers could select if they "strongly agreed," "agreed," remained

“neutral,” “disagreed,” “strongly disagreed,” or were “unsure” in their response to the statement on the survey (Andrews et al., 2014, p. 265). Out of the 75 participants, most teachers (62.7%) agreed or strongly agreed with the statement that it is their “responsibility to support, address, and make any necessary referrals” for students with mental health problems (Andrews et al., 2014, p. 267).

Teachers struggled to identify how to respond to certain student problems. Alisic (2012) conducted a study which utilized semi-structured interviews with 21 elementary school teachers. The researcher attempted to find out teachers' perspectives on how to interact with children after a traumatic event, such as a loss of a parent, serious accident, maltreatment, domestic violence, war, fire, and burglary (Alisic, 2012). Teachers were not selected in a completely randomized design, but they were selected to provide a diverse range of characteristics including based on gender, religiosity, teaching experience, and other factors which may contribute to diverse perspectives. Alisic (2012) found that when a student had a mental health problem, teachers struggled in spending time focusing on providing for the student as opposed to focusing on the needs of the class (Alisic, 2012). Teachers also struggled focusing on the trauma as opposed to focusing on other aspects of the student's life, such as their accomplishments and strengths, and they struggled on how to create a safe environment for students to talk about their emotions and what to talk about during times of crisis (Alisic, 2012).

**Teacher concern.** One problem associated with identifying students with mental problem problems is teachers' views toward them. Although most teachers believe they will encounter students with mental health problems (Moon, Williford, & Mendenhall, 2017), many teachers do not believe all students can learn and achieve at high levels (Erford, 2015). Some teachers have poor attitudes toward mental health

problems because of their lack of knowledge and training for mental health problems (Gleason, Heller, Nagel, Boothe, Keyes, & Rice, 2012). Teachers were more concerned about children with externalizing problems because these students disrupt regular classroom activities, disobey classroom rules, and distract other students (Loades & Mastroiannopoulou, 2010). Because certain mental health problems (e.g., depressive symptoms, negative affective, self-esteem) are inwardly focused and rarely disrupt the regular flow of class, some teachers do not view the identification and support of students with these mental health problems as their responsibility (Roeser & Midgley, 1997). Teachers also often assumed that mental health problems would naturally improve over time as the child develops (Green, Clopton, & Pope, 1996).

**Teacher training.** Teachers are not formally trained in mental health services (Deacon, 2015). Teachers report a lack of experience and training for interacting with and supporting students with mental health problems (Reinke et al., 2011). This lack of experience and training led some teachers to believe they would be unable to accurately identify students with mental health problems (Papandrea & Winefield, 2011; Rothi, Leavey, & Best, 2008). In the RtI three-tiered model, teachers are expected to identify students who are at-risk of or have a mental health problem and subsequently refer them (Stephen et al., 2015). One limitation of this system may be that because teachers are not adequately trained in mental health, they may make inappropriate mental health referrals (Cvinar, 2010).

Teachers lack confidence in their knowledge and competency in dealing with mental health problems (Andrews et al., 2014), especially for inexperienced teachers (Alisic, 2012). According to Andrews et al. (2014), 93.3% of teachers disagreed or strongly disagreed with the statement, "I felt prepared upon graduating from my Bachelor of Education with regards to mental health issues in my students" (p. 268).

Experienced teachers believe that learning through experience was not the best way to deal with students with mental health problems (Alisic, 2012). Teachers want formal training to recognize mental health symptoms (Graham, Phelps, Maddison, & Fitzgerald, 2011; Moon et al., 2017). However, teachers often rely on other faculty in the building for assistance (Andrews et al., 2014). No known study to date examines teachers' perceptions on mental health workshops.

**Barriers to addressing mental health problems.** Teachers perceive barriers that keep students from receiving needed mental health services (Castro-Villarreal, Rodriguez, & Moore, 2014; Reinke et al., 2011). These barriers include a lack of parent-support programs, programs for students with externalizing behaviors, preventative programs for students with internalizing problems, and staff training for mental health problems (Reinke et al., 2011). Teachers have also stated that barriers within the RtI system include a lack teacher training of the RtI process, a lack of time for implementation and data collection, resources, structural problems within the RtI model (e.g., multiple steps, long process for little results), and the substantial amount of paperwork (Castro-Villarreal et al., 2014).

### **Summary**

Teachers have an integrated role in the mental health process within the school system (Eklund et al., 2009). Within the RtI model, teachers have a role of identifying and subsequently referring students with mental health problems, so they can receive the necessary mental health services (Stephan et al., 2015). Teachers often acknowledge their role in this process, but they often express concerns about inadequate teacher training and having the necessary knowledge in dealing with students with mental health problems (Reinke et al., 2011). School counselors consult with teachers about these students, but school counselors do not have the adequate

time or resources to develop a relationship with each student within the school to identify which students need additional services (Erford, 2014). Because of their role within the school, school counselors often rely on teachers to accurately refer students with mental health problems (Eklund et al., 2009). It is important to understand teachers' perception of their role in relation to how they perceive improvements could be made in the mental health process. No known study to date has looked at how teachers perceive mental health workshops to improve teachers' confidence and accuracy in identifying and referring students with mental health problems.

### CHAPTER III

#### **Methodology**

The present study explored teachers' perspectives on their role in the identification of students' mental health problems and their school's mental health system. As previously discussed, mental health among students is a priority of school counselors and teachers are frequently referral agents for students. Understanding how teachers perceive their role in the process will be important in understanding how a school counselor adjusts his or her role.

In this chapter, the methodology of the study will be discussed. Interviews were conducted with teachers using the Demographic Notecard (Appendix D) and the Teacher Interview Protocol (Appendix E). Demographic and qualitative data was gathered based on responses teachers provided using these two instruments. This chapter will review the selection of participants, location of the study, research design, data collection, instruments, data analysis, limitations, and a summary of the methodology.

#### **Research Design**

A non-experimental, qualitative research design was conducted to glean information regarding teachers' perceptions of their role in the identification of mental health problems and the mental health system in their school. This type of design was determined appropriate for the study because the researcher sought to describe and examine how the selected variables exist without any manipulation (Johnson & Christensen, 2006).

The study utilized a qualitative analysis of participants' responses. Qualitative analysis was determined appropriate for the study for several reasons. First, the researchers desired to obtain detailed information about the participants' beliefs,



experiences, and behaviors (Guest, Namey, & Mitchell, 2013). Second, the participants' beliefs and behaviors can be analyzed in an environmental context and through a process and system (Guest et al., 2013). Third, qualitative analysis allows the researcher to explore items in-depth with participants and evaluate or integrate the information acquired during the study (Greene, 1994; Guest et al., 2013). Lastly, participants may provide information or details not anticipated by the researcher (Guest et al., 2013).

### **Location**

One high school was selected and chosen for participation. The location of the study was in rural, southeastern Illinois. This high school enrolls approximately 1,000 students and approximately 75 teachers (Illinois State Board of Education, 2018). The student body is 88.3% White, 4.3% Hispanic, 3.6% Black, 0.7% Asian, and 3.2% Two or More Races (ISBE, 2018). The student population includes slightly less than half of students who are low-income, which is lower than state average, and over one-eighth of students have at least one disability, which is above the state average (ISBE, 2018). There is a higher rate of chronic absenteeism but less chronically truant students than the state average (ISBE, 2018). The school has had multiple traumatic events happen within the last five years.

### **Recruitment Procedures**

Participants were recruited by contacting and collaborating with the school's administration. A preliminary e-mail was sent to the school's principal to clarify of the study's purpose, requirements, and benefits to the school district. Approval from the school's principal and the district's assistant superintendent was acquired after the researcher sent a letter of transmittal (Appendix A). An e-mail (Appendix B) was sent to the school's faculty.

Teachers who desired to participate in the study contacted the researcher and coordinated a time to meet within the school. A copy of the Participant Informed Consent Form (Appendix C) was provided to each participant, and a copy of the Participant Informed Consent Form was kept by the researcher. The Participant Informed Consent Form provides information on the purpose of the study, procedures, potential risks and discomforts, potential benefits to the subjects and society, confidentiality, withdrawal procedures, identification of the investigators, and rights of the research subjects. Teachers received no incentive for participation.

### **Participants**

Participants were recruited from one mid-sized school in the rural, southeastern Illinois. The criteria for participation were high school teachers who normally and regularly have contact with students (>20 hours per typical week) within a classroom setting (see definition, p. 7). Six participants volunteered to participate in the study. Participants represented every grade level (i.e., ninth through twelfth grade) and had teaching experience ranging from one year to over 30 years of teaching experience. Some demographic information has been kept confidential to keep the participants and their responses from being identifiable. Instead of providing a specific number of years of teaching experience, participants are grouped into three categories of experience. The categories are the following: low experience (e.g., 0-5 years), moderate experience (e.g., 6-14 years), and high experience (e.g., 15+ years). Four participants identified as female, and two participants identified as male. Gender-neutral pseudonyms are used to help personalize the individuals and allow the reader follow ideas of individuals while remaining confidential to the identity of the participant. Gender and subject taught are removed from the description of each individual participant to keep the identities of the participants confidential.

Alex (Participant A) has a high amount of teaching experience, has a bachelor of arts, and teaches grades 10 through 12. Alex serves in at least one role with students outside of teaching.

Blaine (Participant B) has a low amount of teaching experiences, has a master's degree, and teaches all grades in high school. Blaine serves in at least one role with students outside of teaching. Blaine has previously worked different teaching positions at a different school.

Casey (Participant C) has a high amount of teaching experience, has a bachelor of arts, and teaches all grades in high school. Casey has previously worked in different teaching positions at different schools.

Drew (Participant D) has a moderate amount of teaching experience, has a master's degree, and teaches 11<sup>th</sup> and 12<sup>th</sup> grades. Drew serves in at least one role with students outside of teaching. Drew has previously worked in different teaching position at different schools.

Emerson (Participant E) has a low amount of teaching experience, has a bachelor of arts, and teaches 9<sup>th</sup> grade. Emerson serves in at least one role with students outside of teaching. Emerson has previously worked in different teaching positions at a different school.

Francis (Participant F) has a low amount of teaching experience, has a bachelor of arts, and teaches 9<sup>th</sup> through 11<sup>th</sup> grades. Francis serves in at least one role with students outside of teaching. Francis has previously worked in a different teaching position at a different school.

### **Data Collection**

Data collection occurred through an in-person, semi-structured interview. Interviews and the explanation of the purpose and benefits of the study lasted between

30 and 60 minutes, depending on the rapport built prior to the interview, potential time constraints of the participants, responses of the participants, and questions posed by participants. Each interview was recorded and transcribed following the interview by the researcher. Recording and transcribing provided the opportunity to analyze the information provided in the interview and reduce errors in human memory, incorrect interpretation of participants' responses, and biases of the researcher. Recording and transcribing also helped researchers highlight thematic responses across participants and help interpret the information provided by the participant.

### **Instruments**

All participants in the study were asked to complete the Demographic Notecard (Appendix D). The Demographic Notecard collects data on the teacher's primary teaching grade, primary teaching subject, previous teaching experience, additional school-based roles, educational credentials, race/ethnicity, and gender. All participants will also be asked to complete the Teacher Interview Protocol (Appendix E). This interview protocol features open-ended questions related to the three research questions. Two questions were added at the beginning of the Teacher Interview Protocol to build rapport. The remaining questions focused on teachers' perception of their role in the process of identifying students' mental health problems, the effectiveness of mental health treatment within their school, suggestions for improvement, and their perceptions on mental health workshops. There were 18 total questions.

### **Data Analysis**

**Qualitative data analysis.** Qualitative analysis was used to summarize responses to each question on the Teacher Interview Protocol. Understanding how teachers' perceptions of their school's mental health system may help school

counselors and other mental health professionals within the school glean information about the what can be done in the mental health treatment process. Teachers may differ in perceptions of the mental health system, and they may provide insight on system changes and individual changes that can be used to improve current schools' mental health systems.

Thematic analysis (Braun & Clarke, 2006) was used to identify and analyze patterns in teachers' responses. Thematic analysis provides a flexibility and versatility in analyzing answers to a variety of questions, and Braun & Clarke (2006) provides a step-by-step approach to effectively utilizing thematic analysis. This approach includes becoming familiarized with the data (e.g., transcribing, reading and re-reading the data, noting initial ideas), generating initial codes (e.g., coding interesting features of the data), searching for themes (e.g., collating codes into themes, collecting all relevant data to each theme), reviewing themes (e.g., checking the relationship of the theme to coded extracts and the entire data set, generating a thematic 'map' of the analysis), defining and naming themes (e.g., refine specifics of the theme, generate clear definitions and names of each theme), and producing the report (e.g., final analysis, extracting examples). In this study, thematic analysis was used to group thematic responses for questions within the Teacher Interview Protocol, except for questions #1, #2, #3b, and #4. These questions are either inserted for rapport building or elaborate on personal stories which cannot be encoded due to the identifiability of students who the teacher might describe.

### **Limitations of the Methodology**

The study was limited in terms of generalizability based on the sample population. Participants may not have been a representative sample of teachers across the country and were geographically limited to one rural Midwestern high school.

Participants were not nationally representative in terms of demographic characteristics (e.g., gender, age), teaching experience, and educational credentials.

Another limitation of the study included the lack of consistency in language across teachers and to the researcher. Teachers frequently used qualifiers (e.g., very, a little) that were not standardized, may have been misinterpreted, or not understood by researchers and may affect the results of the study. Rating scales were not used for teachers to rate their perceptions. To account for this limitation, the researcher reported the language of each participant as he or she made his or her statement to ensure accuracy in reporting.

A third limitation of the study included the biases of the researcher. The researcher may have unknown and unaccounted biases when forming questions in the interview protocol, nonverbally responding to answers by the participants, and interpreting the responses of the participants. To account of some of these biases, the participants' responses were transcribed verbatim to reduce some of the interpretation bias (Berends & Johnston, 2005) but without transcription triangulation.

### **Summary**

In this chapter, several topics have been addressed including the selection of desired participants, location of the study, research design, data collection, instruments, data analysis, and the limitations of the methodology. The chapter focuses on how the researcher collected data on teachers' perception of their role in the mental health identification process, teachers' perception on the effectiveness of their school's mental health system, their suggestions for improvement, and their experiences with mental health workshops. Qualitative data was collected using the Teacher Interview Protocol (Appendix E).

In the next chapter, the results of data collection will be presented. Each research question will be separated with the researcher focusing on broader themes by participants across research questions. The most common themes will be presented first followed by themes which were mentioned less frequently.

## CHAPTER IV

### Results

This chapter focuses on the responses from the participants based on each research question. Many adolescents suffer from some type of mental health problem (Mychailyszyn et al., 2011). It is important to intervene early when someone has a mental health problem to avoid the exacerbation of symptoms throughout the individual's life (Belfer, 2008) and return them to normal functioning (CSMH, 2012). Teachers are often one of the first faculty members to identify students with mental health problems within the school setting (Fredriksen & Rhodes, 2004) because of their relationships with the students and their position to see behaviors and emotions on a normative scale (Headley & Campbell, 2011).

This study provides teachers with the opportunity to discuss their perspectives on the mental health system at their school. Three research questions are posed. They are the following: How do teachers perceive their role in identifying mental health problems within the school system? How do teachers perceive the effectiveness of the identification and treatment of mental health problems within their school? What improvements do teachers have to address mental health problems within the school? Each research question was explored by asking multiple questions on the Teacher Interview Protocol (Appendix E) during the interview with the participant.

Thematic analysis is used to identify similar responses across research questions (Braun & Clarke, 2006). Thematic analysis provides a flexible approach to analyzing participants' responses. Participants may provide different perspectives, use different anecdotes, have different experiences with the mental health system at their school, have unique approaches to solve problems, and have unique suggestions.



Thematic analysis provides a basis for analyzing these unique responses, search for themes within the responses, and effectively analyze those themes.

In this chapter, participants' responses based on each research question will be reviewed. Emerging themes based on participants' responses will be discussed. Lastly, a summary of the identified themes will be provided.

### **Research Question #1**

Five questions from the Teacher Interview Protocol were coded under the first research question. These questions included how teachers perceive their role, how teachers respond when they see a student with a mental health problem, their role after the referral, how prepared they felt for dealing with students with mental health problems, and how teachers' relationships with students impact the students.

**Teachers' perceived role.** Three themes emerged when participants were asked about their role in the mental health identification process. These themes included that teachers are among the first faculty to identify students for mental health problems, teachers often consult with other professionals within the building regarding a student's mental health problem, and teachers often consult with parents and professionals in the community.

**First identifiers.** Three participants identified their role as being the first to identify students. Alex and Francis stated teachers are the "first line of defense." Alex stated teachers will "see the first signs" of mental health problems because they "know if a student changes how they behave [and] how they're reacting" to situations in the classroom. Casey recognizes student behavior that may be "outside the norm," and Francis looks for behavior "out[side] of the ordinary." Casey, who has a high amount of teaching experience, would figuratively, "take the temperature of each student every day" to recognize irregular behaviors.

***Team consultation.*** Three participants found it important to have a team with whom to consult. Alex stated that teachers are not “equipped to deal with every situation.” Blaine and Emerson will consult with team members who have the same student to see if the student demonstrates a similar pattern of behavior. Blaine emphasized the need for “good communication” with the team. Blaine believed it was necessary to “[build] relationships with students,” with “coaching” as one possible way to build a relationship. Alex stated teachers may “refer them” to someone who is equipped to deal with the situation. Not every participant perceived that he or she could refer a student who has mental health problems. Emerson, who has a low amount of teaching experience, stated, “I don’t feel like I have enough training or enough knowledge on the topic of mental health in order to properly be able to refer a student.”

***Consultation outside of school.*** Teachers’ perceptions of their role included consulting with individuals outside the school. Casey and Francis stated that they will “talk to [the] parents” of a child who may have behavioral concerns. Drew perceived it is the role of the teacher to “know what resources are available in my school community” and “know about my community at large too.”

***Teacher behavior.*** Two themes emerged when participants were asked about their response to seeing a student with a mental health problem. These themes included that teachers ask the student either directly or indirectly about their problem or situation and teachers consult with another professional and refer students who have a mental health problem.

***Eliciting a response.*** The first theme from this question regarding asking the student about his or her situation. When seeing a student with a mental health problem, Alex and Francis would pull them out in the hallway and ask the student

what was happening in their life. Blaine, who has a low amount of teaching experience, will look for a student who is “a little more quiet... or [makes] less eye contact.” Blaine will first engage in normal conversation. If the student was reading a book, Blaine will ask, “What are you reading?” If a student reacts oddly and “their body language doesn’t say the same thing,” then Blaine will decide about the next step. Blaine shared that he rarely makes referrals.

***Consultation and referral.*** Participants shared their involvement in the consultation or referral process of the student to other professionals. Emerson, who has less than five years of experience, stated when there is a student exhibiting a mental health problem, Emerson would consult with her professional colleagues within the school district. Alex, Blaine, Casey, Drew, and Francis stated they would send the student to the school counselor or another mental health professional within the school (e.g., social worker, school psychologist). Casey stated, “I’ll have them go see a counselor [if] they can’t function in class.” Blaine, who has limited experience, e-mails the school counselor or the student’s advisor regarding behavioral concerns. However, not every participant referred the student immediately. Emerson will try interventions including moving students’ seating chart or redirecting students.

***Role after referral.*** Three themes emerged when participants were asked about their role after making a referral. These themes included that some teachers receive an emotional response from the student, teachers continue to communicate with referred students, and teachers demonstrate their support for the student.

***Response of the student.*** Several participants spoke about the initial reaction of the student to the referral. Alex and Emerson stated that some students will demonstrate gratitude from the teacher making the referral. Alex, Emerson, and Francis each have experienced some type of backlash. Alex described some students

as standoff-ish and how the teacher-student relationship was damaged. Teachers then had to work to repair their relationships. Per Alex, some students are “really resistant at first.” Emerson, who had a low amount of teaching experience, described the post-referral relationship as awkward.

***Follow-up.*** The second theme identified regarded continual communication after the referral was made. Every participant indicated a continual relationship after the referral process. Casey emphasized to “continue communicating with the student.” Blaine and Drew stated they would “follow up with [his or her] teachers and [his or her] counselor.” Blaine included “contacting parents” in the follow-up process because “the parent relationship can be incredibly important. They’re part of the team even the difficult parents.”

***Teacher-provided support.*** The third theme that emerged was that participants wanted to support the referred student. Three participants emphasized they would provide strong support to the student. Francis would tell the student, “I care about you and that’s why I [referred you].” Drew would “make sure that student knows that there’s help available and that we’re here for them” by showing them that “there’s always someone here unconditionally that listens to them and not judge them.” However, Drew also spoke about how he would not be a parent or a friend to the student but somewhere in-between. Casey would continue to monitor the student to “see if they’re showing any signs that they could be suicidal.”

***Teacher preparation.*** Two themes emerged when participants were asked about how prepared they felt dealing with students with mental health problems. These themes included that teachers believed they were moderately prepared for dealing with students with mental health problems and one teacher felt highly prepared.

***Moderate preparation and training.*** Two themes emerged from this question.

The first theme came from four participants who spoke about being moderately prepared for dealing with students with mental health problems but could use more preparation. Drew explained teachers' preparedness: "I would say on a scale of one to ten, I'm probably about a seven." Drew later continued, "I think I'm prepared as I can be at this point with the resources that we have available." Blaine was fairly prepared and stated, "I'm comfortable with it. I don't know how well prepared I am necessarily." Emerson stated, "I think I could be more prepared." Francis was prepared "if it's something minor... I could talk through those things," but then added "if it's something like severe depression, I definitely need to call somebody else." Alex stated, "as you get your own kids, you feel the [parent] instinct come in... some kids need loving and hugging and they need compassion... some kids need somebody willing to stick their foot on their buttocks."

Participants indicated they had a lack of preparation during training programs. Blaine stated he/she was "not formally trained in it." Emerson described the preparation from undergraduate education: "I spent a lot of time learning about [my subject] in undergrad. Not nearly as much learning about education, or student diversity, or how to think on your feet."

***Highly prepared.*** The second theme was a high degree of preparation. Casey, who has a high amount of teaching experience, was the only participant that was highly prepared for students with mental health problems. Casey stated, "I feel pretty prepared on the front line," and then Casey continued, "I feel like because of my background, I am prepared to deal with a lot of issues that students have."

**Teachers' relationship impact.** Two themes emerged when participants were asked about the impact of their relationship on their students' mental health.

These themes included that teachers' relationships with students had a strong impact on their students' mental health and teachers were role models for their students.

***Strong impact.*** The first theme that emerged from this question was that every participant shared how their relationship with students had a strong impact on their overall mental health. Alex stated that teachers have a "big, impact" on students' lives. Blaine stated, "I think everything in life is about relationships." Blaine continued by saying, "trust is an essential component." Casey believed a teacher's relationships with students "affects [mental health] greatly." Casey continued, "I am very cognizant of how students' view our feelings about them." Emerson stated that teacher relationships have a "positive impact" on the mental health of students. Francis viewed relationships with students as impactful by stating, "my relationship with them is one of the biggest things... it definitely has a positive impact on whatever... they may be going through."

Blaine emphasized that "success is much higher" when a teacher will "build effective relationships and trust." To build those relationship with students, teachers have different methods of communicating and methods of building trust. Francis described caring for students. Drew described classroom as a home for students and would tell students, "You're always safe." Francis was active in students' lives by, "being involved and going and seeing one of their games or asking them how they're doing."

Alex described relationships with students as being a relationship on three different levels: "Do they feel comfortable in your classroom? Do they feel comfortable sitting there or do they feel comfortable talking to you or do they feel comfortable talking in front of the class?" Alex later stated that these levels of comfort can manifest themselves negatively, "If they're fearful of other students, if

they're fearful of you, if they're fearful of the environment for whatever reason, then they aren't going to succeed."

**Role models.** The second theme from this question included two participants stating they see themselves role models for the students. Emerson summed up relationships with students by saying, "a lot of my students don't have many good role models in their life. Sometimes... the only time they see adult role models is when they come into this building." Francis described how some parents are not as involved in the educational process for their child.

## **Research Question #2**

Two questions from the Teacher Interview Protocol were coded under the second research question. These questions included how much teachers knew about their school's mental health system and how effective they believed their mental health system was.

**Mental health system in the school.** Two themes emerged when participants were asked about their school's mental health system. These themes included that teachers were knowledgeable about their school's mental health system and one participant did not know about it.

**Knowledgeable.** Overall, participants were knowledgeable about their school's mental health system. Alex stated, "we have quite a bit in place more so than we ever have." Drew believed the school had a "strong [Emotional Disability] and [Behavioral Disability] program." Blaine stated, "I'm pretty pleased with what we have here." Blaine responded positively to the high "level of communication that I have and receive from administration [and] from student services." Per Blaine, the system includes "administration and a principal who is deeply invested in us as a group of professionals." Blaine, Casey, and Francis mentioned counselors, social

workers, psychologists, and interns as integral parts of the mental health system.

Blaine explained that each counselor in student services has about 250 students, and those counselors are “in charge of understanding those families.” Outside services are also a part of the system. Casey shared that a community counseling service “comes to our school” to meet with students. Per Francis, “we have a variety of resources that we use to not only, I guess, find the kids that are in need but help those kids that are in need too.” These resources may help reach more students than the school has previously reached. As Alex stated, “we’re seeing more and more [mental health screenings] for kids that aren’t identified yet.”

***Lack of knowledgeable.*** A second theme that emerged was a lack of knowledge about the school’s mental health system. Emerson stated, “I don’t know a lot about the mental health system at my school.” All other participants provided some description of their school’s mental health system.

***Mental health system effectiveness.*** Three themes emerged when participants were asked about the effectiveness of their school’s mental health system. These themes included that some teachers discussed the strengths of their system, some teachers believed improvements could be made, and some teachers discussed weaknesses of their school’s mental health system.

***Strengths.*** Only one participant had a strong and positive outlook on the school’s mental health system. Alex stated, “we’re very, very well equipped to do that, and I think we’re very successful at it.” However, Alex acknowledged that some students “slip through the cracks.”

***Improvements needed.*** Two participants had a positive outlook but stated that improvements could be made. Although Drew shared, “we’re as good as we could possibly be at this point.” Drew continued, “I think there’s more professional



development needed.” Drew also expressed a positive outlook about the teachers’ efforts in the process, “[teachers’] hearts are in the right place.” Casey explained, “we’re getting better, but I think we need more.” Casey also stated that the severity of the mental health problems influences the school’s effectiveness: “when they’re not as serious, I think we’re excellent. When they reach that point of say homebound, we’re somehow not reaching those kids.” Although Alex was generally optimistic about the mental health system, Alex also expressed the difficulty in identifying students with mental health problems because students are “master[s] at hiding what they don’t want you to see” and “they’ll pick and choose who sees what.”

**Weaknesses.** Three participants, who all had a low amount of teaching experience, had a negative outlook on the mental health system within the school. Emerson stated, “I think that the school system is overwhelmed with mental health problems.” Emerson continued, “I already think that we’re dealing with a lot more anxiety than schools have dealt with in the past,” which includes, “cyberbullying or all the uses of social media.” Francis stated, “I would say there’s half the people that are very, very good at what they do, and I feel like half the people are not in it for the right reasons.” Francis said, “There are people who don’t truly care about the well-being of students, or maybe they do, and they just don’t know how to show it.”

Blaine acknowledged several limitations within the mental health system. These limitations included “legal and... regulatory structures [that] create constraints.” Schools may be legally required to act “in defiance of what parents want.” The distribution of resources was also concerning. Blaine explained, “I think there is a tendency to focus on the discreet minority on the very small subset of students and we begin shifting a ton of resources in that direction often at the detriment of the broader population.” Blaine stated that class sizes were a limitation

to the effectiveness of the school's mental health system. "If you have a classroom of 20 kids, we don't ignore that problem and yet we can't ignore 19 for one either."

### **Research Question #3**

Five questions from the Teacher Interview Protocol were coded under the third research question. These questions included teachers' suggestions on improvements to their school's mental health system, barriers to effective service delivery, how support staff can assist them, their experiences with mental health workshops, and their commitment to mental health workshops.

**System improvements.** Three themes emerged when participants were asked how to improve their school's mental health system. These themes included that teachers suggested more training was needed, more resources should be available, and methodological changes to the mental health system were necessary to make improvements to the system.

**More training.** The first theme that emerged regarding improvements to the school's mental health system was participants wanted more teacher training for mental health problems. Blaine, Drew, and Emerson each mentioned more training could be an option for improvement. Blaine mentioned a potential change to the structure of student-based meetings: "the team [could] met for 15 or 30 minutes before the parent and/or student was sitting there" as a "strategy huddle." Blaine acknowledged that it was "hard to find time and get the team together" for additional discussion of students.

**More resources.** The second theme regarding improvements to the mental health system was that participants wanted more resources to be available. One participant stated, "time being one of our biggest resources." Casey mentioned greater use of group counseling, the use of community mental health agencies, and

more one-on-one counseling with students. Alex described wanting self-help and student-driven groups to have adolescents work out their own mental health problems.

***Methodological changes.*** The methodology of handling some mental health situations was discussed by two participants. The idea that some students need “tough love” was mentioned by Alex and Francis, who both had low amounts of teaching experience. Francis explained, “Talking about their feelings... is great” but “if they’re being a little soft... we’re going to have to find a way through it.” Francis continued, “That is very, very true about the real world, not so much in the school.” Francis suggested teachers should be more “proactive” in helping students overcome obstacles by saying, “It’s okay to be upset, but we have got to find a way to get over it.” Drew contrasted this view by saying, “the old school kind of mind set of just kind of carry on and deal with it” may be a barrier if teachers “don’t believe that mental health issues should be handled.”

***Barriers to effectiveness.*** Two themes emerged when participants were asked about barriers to the effectiveness of mental health identification and treatment of mental health problems at their school. These themes included that the school lacked resources to providing effective mental health and teachers thought other teachers’ perceptions of mental health are a barrier for students to receive services.

***Lack of resources.*** One theme that emerged from this question regarded a lack of some type of resource or access to those resources. Alex, Casey, and Emerson each mentioned a lack of at least one of the following resources: funding, time, and/or training. Emerson stated, “training is out there,” but teachers first need to acquire access to it. Blaine mentioned that teachers’ experience in identifying mental health problems was a barrier to accurately identifying mental health problems.

***Teacher perceptions.*** The second theme from this question regarded individual's perceptions of the mental health system in their school. Casey stated that teachers often do not want students pulled out of their class for counseling-related services. "All of us feel like our class is the most important... Sometimes we have to get over those kind of barriers." Drew also talked about the stigma associated with mental health problems and shared, "Mental health issues are not necessarily a negative" and are "not supposed to be a crutch to stop you from succeeding or pushing yourself."

There were two additional potentially pertinent comments by participants although they were not thematic across multiple participants. First, Blaine identified how "cultural barriers" exist to address certain types of mental health problems; however, Blaine did not elaborate on what those barriers were, and the researcher did not ask any follow-up questions. Second, Alex was concerned over how involved teachers should be in a student's life, "We can't ask kids, or we can't address [mental health problems] with kids because there's an unspoken wall between how far do you go, how far do you push, how far do you get involved."

**Support staff assistance.** Two themes emerged when participants were asked how support staff, such as school counselor or social workers, could assist teachers. These themes included that support staff should communicate with teachers and provide mental health workshops for teachers to learn about mental health problems in their role as a teacher.

***Communication.*** The first theme that emerged from this question regarded communicating the student's mental health problem with teachers. Blaine would like counselors to, "communicate to us the individual circumstances or diagnoses." Blaine continued by wanting to know "the array of treatments and responses specific to the

classroom.” Drew wanted to be informed of students’ mental health problems “through a database or through a paper copy.” Francis also wanted a “chart” and counselors to inform the teachers by saying, “You might want to be on the watch out for this.”

***Mental health workshops.*** The second theme regarded the opportunity for teachers to attend a workshop on how to identify students with mental health problems. Alex stated the school has done a good job of “giving us in-services.” Alex had attended an in-service which “talked about key signs and key components that you can identify.” Casey stated, “Give us a workshop on how to identify those students who maybe we’re missing.” Emerson stated that the social service faculty should “[lead] the training” because “they’re the ones that are trained in identifying [mental health problems].” Lastly, Drew wanted to know from the social service faculty “what’s worked [and] what hasn’t worked.”

***Experiences with mental health workshops.*** Two themes emerged when participants were asked about their previous experiences with mental health workshops. These themes included that some teachers believed mental health workshops were effective and some teachers had believed mental health workshops were ineffective.

***Effective.*** The first theme from this question was that three participants believed mental health workshops were effective. Alex, who has a high amount of teaching experience, stated one workshop was “life changing,” and that this workshop “dealt with suicide, it dealt with bullying, it dealt with self-harm, it dealt with family issues, it dealt with self-perception.” Alex described mental health workshops” as “really, really... beneficial.” These workshops can help you “[realize] what you can

deal with and what you can't deal with." Alex stated that workshops are important because teachers sometimes "[do] not feel equipped to dive into that issue."

Blaine, who has a low amount of teaching experience, had attended an "amazingly well-done" workshop which "talked specifically about suicide." Blaine stated that mental health workshops can teach you "proper interventions and services" and how "to do [them] effectively." Blaine continued, "I do think that in-services are helpful." Casey, who has a high amount of teaching experience, attended a mental health workshop which was "enlightening" about "those students who you might miss." Casey believed workshops are "extremely important." "It's got to be in your toolbelt that you can identify those kids," and it would be "very beneficial if we would expand [the toolbelt]."

***Mixed effectiveness.*** The second theme which emerged was that a mixed view of the effectiveness of mental health workshops. Drew, who had a moderate amount of teaching experience, thought mental health workshops are "amazing," but the workshop "has to be effective." Drew attended a workshop that was "really great" where "law enforcement officials... come in and give some of the background on some of the cases they see and a lot of it is about this person had this happen to them in childhood, and it created this mental health issue." However, mental health workshops can become repetitious: "I'm just hearing the same thing that I've already been told." In response to these experiences, Drew suggested to "give us different workshop options that we can choose that related to what we need."

***Ineffective.*** The second theme from this question was that two participants believed that mental health workshops were ineffective. Mental health workshops can become repetitive and lacked useful content, and some participants stated that attending the same or similar workshops was not helpful. Francis, who has a low

amount of teaching experience, stated, "I've never really been to a workshop that I feel was productive." Francis explained, "You have a kid. You try, try, try. It doesn't work. You go on to the next kid." Per Francis, workshops may need to be effectively marketed to teachers: "I think if you could get all the teachers to buy in, it'd be great." Teachers today must adjust to new situations: "kids you're dealing with nowadays are different... [the] stress of social media... kids are more hypersensitive... they have unlimited information at their fingertips."

Emerson, who has a low amount of teaching experience, also believed that mental health workshops were ineffective. Emerson stated, "I think the only professional development or workshop that I've ever been to... [was] where we watched [a] movie." Emerson continued, "The movie itself was incredible. The application not so much." Emerson stated, "I think if implemented correctly, that [mental health workshops] would be very effective." Emerson described mental health experiences: "Sometimes I feel we go to professional developments that are kind of just thrown together last minute."

**Commitment to workshops.** Two themes emerged when participants were asked about their school's mental health system. These themes included that some teachers would dedicate a high amount of commitment and some teachers would dedicate some time to attending mental health workshops.

***High level of commitment.*** The first theme which emerged from this question was that some participants would dedicate a lot of their time toward learning about mental health. Several participants stated they would like continuing educational units, which are credits teachers are required to take to keep up their professional development. Blaine explained, "The investment of time and training and preparing... would pay huge dividends." Drew stated, "as much time as we could

make.” Casey stated, “whatever time that we feel is necessary.” Casey continued by stating, “If their mental health is not okay, they’re not going to learn your [subjects].” Francis would attend workshops “if I thought that it was going to make a difference” several days dedicated to the workshop. Casey added, “I don’t really think that most of us would need an incentive.” The workshop needs to be meaningful but “it’s the right thing to do.”

Participants also discussed the time they would allocate to mental health workshops. Drew and Francis stated they would be willing to complete the professional development in the summer. Drew stated, “It has to be effective training.” Drew was willing to commit to mental health workshops: “I’ll help the kids that we serve.” Blaine stated, “I would give up some evenings and even potentially a weekend or two.” Blaine did not need many incentives to attend workshops: “Knowing that you’re making a difference is the ultimate incentive.” Similarly, Francis stated, “If it’s going to help the kids, sign me up.” Participants were mixed on dedicating a weekend to professional development: Blaine would attend a workshop on a weekend, but Francis would not.

***Some commitment.*** The second theme which emerged from this question was that participants generally would dedicate some of their time but not a lot of their time due to time constraints or other factors. Alex wanted to dedicate some time to attending workshops: “quite a bit... [but] I don’t know if there’s a set amount I would do.” Emerson stated, “I’d be willing to put an entire professional development day into it. You know maybe two.” However, “teachers don’t have a lot of time.” Drew hesitated on the length of the professional development: “I don’t want a weeklong one.” Emerson suggested pay to incentive workshop attendance. Both Alex and Emerson restricted their time commitment. Alex wanted workshops during the day



because it would otherwise “[take] away from my family time because that’s taking away from my mental health and from my family’s mental health.” The professional development needs to be worth the time: “If I thought that it was going to make a difference, I would definitely donate a day or two to it.”

### **Summary**

Several themes emerged throughout participants’ responses. Teachers frequently viewed themselves as the first professionals to identify students with mental health problems. After they have identified a student, teachers believed they should discuss with the student what the teacher is observing. Teachers often will consult with professionals or the students’ parents and then refer the student if necessary. Teachers may have to repair their relationships with that student because the student may be upset with him or her for making the referral.

Participants had mixed responses about the effectiveness of their school’s mental health system. Several participants discussed its strengths, and several participants discussed its weaknesses. Most participants believed mental health workshops were effective if they were meaningful and provided applicable information. Some participants were not receptive to mental health workshops hosted in the evening or on the weekends. Most teachers stated they did not need many incentives to attend but would more readily attend workshops if the workshops were during school hours and if the teachers received pay, continuing education units, and/or food.

## CHAPTER V

**Discussion**

This study examined teachers' perceptions of their role in the identification of mental health problems in students, how effective their school's system is at addressing mental health problems, and their suggestions for improvement. The researchers sought to acquire in-depth data on teachers' perceptions and beliefs. Teachers are often the first to identify adolescents with mental health problems because of their unique position in a classroom (Johnson et al., 2011), so their input into the process of mental health treatment is valuable and may inform other teachers, school administrators, student service staff, and researchers.

The first research question asked how teachers perceive their role in the identification of students' mental health problems. Participants frequently stated that they were often the first identifiers of the signs of mental health problems within students. Participants generally acknowledged their role in the mental health identification process. Teachers' position to view student behavior on a relatively normative scale (Headley & Campbell, 2011) and the frequency of students trusting in and confiding in teachers (Fredriksen & Rhodes, 2004) allows teachers to be ideal identifiers of mental health problems in students. Several teachers stated that their relationships with students strongly impacts the student's mental health, or research supports building strong relationships with students to positively impact them (O'Connor & McCartney, 2007). Teachers can utilize their relationships with students to support and refer students at-risk of mental health problems (Kourkoutas & Giovazolias, 2015). In this study, every participant discussed referring students to other professional. However, participants with a low amount of experience discussed trying to address the mental health issues within their classrooms before referring the

student to another working professional (e.g., school counselor, social worker). Several participants emphasized the importance of building relationships with parents.

When a teacher observes a student with a mental health problem, the role of consultation is important in successfully addressing the mental health problem (Dowdy et al., 2015). Several participants described consulting with teachers on their team or counselors about the behavioral concerns of students within their class. The RtI model provides the opportunity for teachers and counselors to collaboratively solve mental health problems within the school setting (Stephan et al., 2015), which integrates social, emotional, and behaviors needs of the student (Macklem, 2011). Teachers often confide in other faculty for consulting with students with mental health problems (Andrews et al., 2014). Three participants disclosed receiving backlash from the students they referred because of the referral. It will be important for the teacher to build up the trust of the student again and develop a strong relationship with him or her to maintain desirable outcomes (O'Connor & McCartney, 2007).

Participants reported being moderately prepared for dealing with students with mental health problems. Previous research also found that teachers lacked confidence of dealing with mental health problems (Andrew et al., 2014). One participant described how undergraduate education did not adequately support training in mental health problems. Participants with higher levels of experience stated that experience helped prepare them for dealing with students who had mental health problems. However, experience may be problematic for some teachers (Reinke et al., 2011). Teacher preparation will be important for developing a universal model of mental health problem prevention (Dowdy et al., 2010).

The second research question regarded the effectiveness of the mental health system. This question is important because the effectiveness of the mental health

treatment system depends on the identification of at-risk students (Lynch et al., 2015). Most participants positively responded to their school's mental health system; however, participants who were less experienced tended to believe their school's mental health system was not sufficiently effective. For example, both Emerson and Francis had a low amount of experience and believed their mental health system could make significant improvements. There were no clear agreements among participants as to how to improve the mental health system, and no participants provided detail on improvements they would like to see happen. Teachers with more experience had the benefit of seeing changes to the system over time and how those changes affect mental health outcomes.

Participants discussed the limitations on the school's mental health system. Blaine stated that a lot of resources are now devoted to a small number of students. In schools, the severity of the mental health problem is linked to whether they receive treatment (Merikangas et al., 2011). Thus, it remains problematic if resources are available for all students, yet not all students receive useful services. Additionally, Blaine had concerns about the focus of resources. The school system cannot focus on one or a few students while ignoring all other students. Teachers in the past have struggled on how much time and resources are focused on an individual student as opposed to the class (Alisic, 2012).

The third research question focused on improvements to the mental health system. Participants stated they believe more training and resources would benefit the mental health system in their school. Stigmas, time, and resources were barriers frequently discussed. Improvements teachers can make include removing social stigmas which create barriers for receiving services, holding students to high yet attainable standards, and taking mental health problems seriously. Stigmas against

mental health treatment may prevent adolescents from seeking services because of how peers may perceive them (Gulliver et al., 2010). One participant stated that some teachers either do not care or do not know how to demonstrate care for students. If all teachers buy-in to supporting students' mental health, the teacher identification rate may improve. Improvements for counselors should include the best practices within the field, including family involvement and developing and maintaining the therapeutic alliance (Karver, Handelsman, Fields, & Bickman, 2005).

Teachers were asked about their experiences with mental health workshops, and their responses were mixed with several participants perceiving that the mental health workshops they've attended in the past were beneficial and several participants perceiving that mental health workshops were not beneficial. Alex positively responded describing the workshops as containing information related to bullying, suicide, self-harm, family issues, and self-perception and were helpful. Drew described a mental health workshop where a law enforcement official described the childhood background on some cases involving adults having mental health problems. It is unknown the real-world effect these workshops had on teachers' mental health identification rate or any behavioral changes of teachers in the classroom.

Several participants responded by saying mental health workshops were not productive or did not provide specific information on how to interact with students with mental health problems. These same participants remained somewhat optimistic by saying that the workshops need to be meaningful and marketed well to teachers. Nearly every participant stated that mental health workshops should be meaningful or provide effective training. Teachers are limited in time and resources, so whatever time they dedicate to mental health workshops must be worth the investment.

Overall, participants positively responded toward time commitment and incentives to attend mental health workshops. Few participants would offer a lot of time, but at least two participants would be willing to dedicate some time during summer break, weeknights, or weekends. However, not every participant would take personal time beyond school hours to attend a workshop. Frequently mentioned incentives included continuing educational units, lunch, pay, and the effectiveness or meaningfulness of the workshop.

### **Recommendations**

The information obtained in this study will help administrators, teachers, counselors and other support staff, parents, and researchers on general recommendations regarding schools' mental health systems. Teacher relationships with students are important, as students often look to teachers as role models (Fredriksen & Rhodes, 2004). Teachers should develop trust and demonstrate support for students who have mental health problems (Fredriksen & Rhodes, 2004). When teachers experience resistance or receive resistance after a referral, teachers should continue to provide support to the student. High quality teacher-student relationships are associated with desirable outcomes (O'Connor & McCartney, 2007), so it will be important for teachers to reacquire the student's trust.

Teachers are not trained in mental health treatment but can provide appropriate referrals to counselors and other support staff. Some participants frequently consulted with other experienced teachers and support staff who provide an additional perspective on how to interact with the student. If teachers have difficulty finding time for individual students, it is recommended that teachers refer out and let the counselor develop a strong relationship with the student. Counselors typically work one-on-one with students or work with groups of students.

Three participants mentioned wanting a database or a chart for information on students' situations. Teachers should have access to the cumulative file of the student. However, sharing specific information in a counseling session may be considered an ethical and/or legal violation, and counselors can only disclose certain types of information in specific instances (American School Counseling Association, 2016). Counselors and other support staff should continue to consult with teachers regarding students they refer and provide teachers with appropriate classroom-based interventions. Counselors and other support staff should also communicate what they can and cannot share with teachers to manage teacher frustration and inform them that their referred students are receiving services.

Finally, counselors and other support staff may use the information obtained in this study to act as an agent of change. It is recommended to utilize best practices within the field of counseling including family involvement and having a strong relationship with the student (Karver et al., 2005). For counselors and other faculty who provide workshops for mental health training, the information provided from several participants within this study was consistent. Participants wanted workshops to be to the point and provide applicable information on what they should be doing differently in the classroom. Some participants mentioned role playing or the use of vignettes with students who they may see in their classrooms. Participants were generally willing to attend workshops, and several participants mentioned willingness to attend workshops during the summer, weekends, or week nights. However, not every participant stated willingness to attend workshops during these times, and workshops should be prepared during times in which participants are willing to attend. Offering non-mandatory trainings for teachers during these times may provide opportunities for quality workshops. Participants stated that they would be willing to

attend workshops for reasonable incentives, including professional development credits, lunch, and pay if it was during the day.

### **Future Directions**

There are several directions for researchers to acquire new and valuable information based on this study and the present studies conducted. The same study could be conducted with more participants who work in different settings and with different populations. Acquiring more and varied perspectives on the mental health system within schools may provide more insight on how to successfully operate and improve the system.

No known study has identified effective mental health workshops for teachers. It is currently unknown which workshops, if any, have worked well for teachers. The contents and applicability of efficacious workshops are presently unknown. To improve the mental health system for teachers, researchers will need to analyze the outcome effects of attending mental health workshops and determine which workshops are the most helpful.

Teachers often link students to the services they need (Mychailyszyn et al., 2011). It is currently unknown which workshops, if any, increase the teacher identification rate of students with mental health problems. Teachers may recognize signs of students with severe depression, anxiety, or other mental health problems. However, students with moderate mental health problems may not receive beneficial services because teachers may not recognize the signs and symptoms of mild or moderate mental health problems. Mental health workshops may help assist teachers in recognizing these signs and symptoms and increase the accuracy of referring students who need mental health services.



**Summary**

Participants in this study discussed their perceptions of their role in the mental health identification process, the effectiveness of their school's mental health system, and their suggestions for improvement. Teachers are key in linking mental health services to students who need them. In this study, teachers recognized their role in the mental health identification process. All teachers discussed how they consult with parents, professionals, or their professional teams about their students who may have mental health problems. Less experienced teachers discussed how they frequently would attempt to address the problem before a referral. Sometimes teachers received resistance from the student because of a referral, and teachers worked to repair the relationship. The response from participants regarding the effectiveness of their school's mental health system was mixed, and less experienced participants tended to believe their school's system was ineffective and needed improvement. Participants believed more training and resources were needed for addressing mental health. All participants were willing to attend mental health workshops; however, time was a limiting factor for participants, and workshops need to be meaningful and applicable for participants. Recommendations for teachers include developing and maintaining strong relationships with students, attending quality mental health workshops, and consulting with other professionals and parents about the nature of a student's mental health problem. Recommendations for counselors and other support staff include consistent consultation with teachers regarding students they refer and making workshops for teachers which provide meaningful and applicable information.

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**Appendix A****Letter of Transmittal**

September 6, 2018

Mattoon Faculty  
Mattoon High School  
2521 Walnut Avenue  
Mattoon, IL 61938

Dear Mattoon High School Teacher,

I am pleased to report that Mattoon High School has been selected and approved for research through Eastern Illinois University's School Counseling program. The study is a qualitative interview regarding your perceptions on your role in the mental health process, the effectiveness of Mattoon High School's mental health system, and your ideas for improvement. Interviews are conducted in-person and are expected to take between 60 and 90 minutes. Six to nine participants are desired. All participating teachers' information and answers will be kept strictly confidential. The study's results will be shared with the Mattoon High School district.

If you have any questions or concerns regarding the study, please do not hesitate to contact either myself or my thesis chair, Dr. Heidi Larson. Your consideration and participation are much appreciated.



Sincerely,

Nick Caldwell

M.S. Candidate in School Counseling

Department of Counseling and Higher Education

Eastern Illinois University

Dr. Heidi Larson, Ph.D

Professor

Department of Counseling and Higher Education

Eastern Illinois University

**Appendix B****E-mail to Participants**

Dear \_\_\_\_\_ faculty,

I am pleased to announce that \_\_\_\_\_ High School will be the host of a research project conducted through Eastern Illinois University by myself, Nicholas Caldwell, B.A., and Dr. Heidi Larson, Ph.D. I am looking for 6 to 10 teachers who are willing to dedicate 60-90 minutes of their time for an interview. Teachers will discuss their perceptions regarding their role in the mental health process, the effectiveness of their school's mental health system, and suggestions for improvement. The purpose is to develop a greater understanding of how teachers perceive the mental health system and give them a voice for their praises or concerns.

Interviews will be voice-recorded and transcribed to ensure accuracy of answers. All records will be destroyed among completion of the study. All information about participating teachers will be kept strictly confidential to allow free and honest responses and their answers will be coded. Teachers will not be identifiable as a result of this study. The results collectively will be shared with your school district.

If you are interested in participating in the study or have any questions, please contact Nicholas Caldwell (e-mail: \_\_\_\_\_; phone: \_\_\_\_\_) to set up an interview at your convenience. I thank you for your time and consideration.

Nick Caldwell, B. A.

**APPENDIX C****PARTICIPANT INFORMED CONSENT FORM***Teachers' Perception of Mental Health in the School System*

You are invited to participate in a research study conducted by Nicholas Caldwell, B. A., and Heidi Larson, Ph.D, from the Department of Counseling and Higher Education at Eastern Illinois University.

Your participation in this study is entirely voluntary. Please ask questions about anything you do not understand before deciding whether to participate. If you choose to participate, you are free to stop and withdraw from the study at any time for any reason.

**• PURPOSE OF THE STUDY**

The purpose of this study is to examine teachers' perceptions of the following: their role in the mental health identification process within the school system, the effectiveness of the mental health process within their school, suggestions for improvement of the mental health process, and mental health workshops for teachers. Participants will have the opportunity to respond to open-ended questions regarding these topics and may add additional information if they so choose. It is important to understand teachers' perceptions of the mental health process within the school if we want to improve the system for children and more accurately identify, refer, and treat students with mental health problems.

**• PROCEDURES**

If you volunteer to participate in this study, you will be asked to complete the following:

1. Sign the Participant Informed Consent Form. There is a participant copy and a researcher copy. Both signatures are required for participation, and the informed consent form must be turned in before you can participate in the study.
2. Complete the Demographic Notecard. This form asks you about your teaching experience, grades and subjects taught, race/ethnicity, gender, and your teaching credentials.
3. Complete the Teacher Interview Protocol. This form involves the open-ended questions regarding your perceptions on the mental health process within the school. Participants are free to refuse to answer any question on the protocol for any reason and may add additional information if they desire.

The study will be conducted in a one-on-one setting and in a confidential location. The session will be audio recorded to ensure full and accurate representation of your responses. The audiotape will be transcribed, and you will have the opportunity to amend the transcript after its completion if you desire. You may decline this option.

- **POTENTIAL RISKS AND DISCOMFORTS**

There are minimal risks/discomforts for you if you choose to participate. The questions on the Teacher Interview Protocol are related to your experiences with students with mental health problems and your perceptions on how mental health is identified and treated within your school. This may cause some slight psychological discomfort. If you become distressed or discomforted by any question(s) on the Teacher Interview Protocol, you may refuse to answer that question for any reason. You are also free to withdraw from participation at any point. Participant health and safety is the primary concern.

The researchers report no immediate physical, social, legal, or financial risks associated with participation in this study.

The study may be terminated only if there are not enough participants to successfully complete the study. All participants will be notified if this happens.

- **POTENTIAL BENEFITS TO SUBJECTS AND TO SOCIETY**

This study will be used only for research purposes. This study will help you and other teachers disclose your perceptions of the mental health process within your school. You may recognize their own strengths or weaknesses related to how you and other faculty identify mental health problems within the school.

This study will also help the school determine their best solutions. You can offer suggestions and provide insight without fear of the conflict of interest between you and your administrative staff by participating in this study. You may provide unique perspectives, and administrators will respond and adjust accordingly. You may see their suggestions systematically incorporated into the school system.

Society may also benefit from the knowledge acquired in this study. If you offer insight about your perceptions in the mental health process, schools nationwide may adapt to teachers' unique needs, perspectives, and suggestions for improvement. If we want our children to live in the best possible world, it will be essential to consider the perspective of the individuals who work very closely with our children: teachers.

- **INCENTIVES FOR PARTICIPATION**

No incentives will be offered for participation or completion of the study. Participants volunteer for the study of their own free will.

- **CONFIDENTIALITY**

Any information that is obtained from this study and any identifying information will remain confidential. The direct information (e.g., audiotape and transcripts) will only be accessible by the researchers and you if you choose to access them. Dissemination of information will only occur with your written permission or as required by law. Confidentiality will be maintained by means of maintaining a secure location behind two locked containers. Upon successful completion of the study, all physical data

will be destroyed after three years. The research findings in this study may be published. However, no personal information will be published under any circumstances and all personal information will be destroyed upon completion of the study.

- **PARTICIPATION AND WITHDRAWAL**

Participation in this research study is voluntary and not a requirement or a condition for being the recipient of benefits or services from Eastern Illinois University or any other organization sponsoring the research project. If you volunteer to participate in this study, you may withdraw at any time without consequences of any kind or loss of benefits or services from sponsoring organizations to which you may otherwise receive.

You may also refuse to answer any questions you do not want to answer.

- **IDENTIFICATION OF INVESTIGATORS**

If you have any questions or concerns about this research, please contact:

*Nicholas Caldwell, B.A.*

M.S. Candidate in School Counseling

[njcaldwell@eiu.edu](mailto:njcaldwell@eiu.edu)

641-590-4869

*Heidi Larson, Ph.D*

Associate Professor, Student Counseling and Development

[halarson@eiu.edu](mailto:halarson@eiu.edu)

217-581-7236

- **RIGHTS OF RESEARCH SUBJECTS**

If you have any questions or concerns about the treatment of human participants in this study, you may call or write:

Institutional Review Board

Eastern Illinois University

600 Lincoln Ave.

Charleston, IL 61920

Telephone: (217) 581-8576

E-mail: [eiuirb@www.eiu.edu](mailto:eiuirb@www.eiu.edu)

You will be given the opportunity to discuss any questions about your rights as a research subject with a member of the IRB. The IRB is an independent committee composed of members of the University community, as well as lay members of the community not connected with EIU. The IRB has reviewed and approved this study.

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I voluntarily agree to participate in this study. I understand that I am free to withdraw my consent and discontinue my participation at any time. I have been given a copy of this form.

\_\_\_\_\_  
Printed Name of Participant

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

I, the undersigned, have defined and fully explained the investigation to the above subject.

\_\_\_\_\_  
Printed Name of Investigator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_  
Date

Participant's Copy

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I voluntarily agree to participate in this study. I understand that I am free to withdraw my consent and discontinue my participation at any time. I have been given a copy of this form.

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Printed Name of Participant

---

Signature of Participant

---

Date

I, the undersigned, have defined and fully explained the investigation to the above subject.

---

Printed Name of Investigator

---

Date

---

Signature of Investigator

---

Date

**Appendix D****Demographic Notecard**

## Section A: Teacher Demographics

- 1) What grade(s) do you primarily teach?
- 2) What subject do you primarily teach?
- 3) How many years of teaching experience do you have?
- 4) What is your previous teaching experience?
  - a. Please list the school, the number of years taught.
  - b. Please list any other roles you may have served in the school (e.g., paraprofessional, tutor).
- 5) What educational credentials do you hold (e.g., Bachelor of Arts, Master's Degree)?
  - a. In what field are your credentials (e.g., Math Education, All Science Teaching)
- 6) What is your race/ethnicity?
- 7) What is your gender?



## **Appendix E**

### **Teacher Interview Protocol**

- 1) Tell me about your proudest teaching moment.
- 2) Tell me about your biggest challenge as a teacher.
- 3) Teachers are important in referring students to other faculty, such as school counselors or school psychologists, who are trained in mental health treatment.

How do you perceive your role in the mental health identification process?

- a. What do you do when you observe a student who may need mental health support?
  - b. Tell me about a time when you referred a student for mental health problems.
  - c. Describe your role with the student after making a referral.
  - d. Describe how prepared you feel dealing with students with mental health problems.
- 4) In what ways do you see mental health impacting academic achievement and student behavior?
    - a. In what ways do you believe your relationship with your students impacts their overall mental health?
  - 5) Tell me about the mental health system, such as RtI or MTSS, at your school.
    - a. How effective do you believe your school's system is at treating mental health problems?
  - 6) What improvements, if any, do you believe could be made to your school's mental health system?
    - a. What barriers currently exist at your school for improving students' mental health?

- b. How might your school's school counselor, social worker, or school psychologist assist you in identifying students with mental health problems?
- 7) Tell me about your experiences with mental health workshops or professional development related to mental health.
  - a. How effective do you believe training or professional development with students' mental health are, or would be, for teachers?
  - b. How much time, if any, would you be willing to dedicate to learning about adolescents' mental health problems?
  - c. What incentives would make you more likely to attend more mental health workshops?